HB 1393

Authorizes the managed care assessment fee to be assessed against specified insurers and administered by the office of the secretary of family and social services. Establishes the managed care assessment fee committee. Sets forth requirements of the managed care assessment fee. Establishes the high risk pool fund. Expires the managed care assessment fee on June 30, 2025. Allows certain providers to contractually agree to a different reimbursement rate with a managed care organization as part of a value based services contract. Excludes hospitals and private psychiatric hospitals. Provides for payments to hospitals out of the phase out trust fund and expires the fund. Exempts: (1) physician owned hospitals; and (2) hospitals that only provide respite care to certain individuals; from the hospital assessment fee. Makes assessment of the hospital assessment fee subject to federal approval of changes made by this act. Requires the hospital assessment fee committee to: (1) review and approve the quality program; and (2) be guided to ensure hospitals are reimbursed at a rate that meets specified requirements. Specifies components of a state directed payment program. Specifies uses of the hospital assessment fee and that hospital assessment fees will not be used for disproportionate share payments if the state directed payment program is implemented. Reduces the hospital fee assessment by the managed care assessment fee and the payment from the phase out trust fund. Requires the commissioner of the department of insurance to revoke or suspend the authority of a managed care organization to do business in Indiana if the managed care organization fails to pay the managed care assessment fee. Repeals language concerning the hospital care for the indigent program. Repeals language specifying the distribution of the hospital assessment fee.

SB 237

Amends the law on health care service prior authorizations: (1) to establish a standard by which to determine whether a health care service is “medically necessary”; (2) to require that the medical review or utilization review practices of a health plan be governed by this standard of medical necessity; (3) to require a health plan to employ a medical director who is responsible for reviewing and approving the health plan’s policies on responses to requests for prior authorization; (4) to require a health plan to establish clear written policies and procedures for prior authorization for health care services; (5) to restrict a health plan’s prior authorization requirements applying to: (A) physical medicine or rehabilitation services for a covered individual diagnosed with chronic pain; and (B) rehabilitative or habilitative services, including physical therapy, occupational therapy, and chiropractic services; (6) to provide that, under certain circumstances (including the failure of a health plan to respond to a request within certain time limits), a request for prior authorization is conclusively considered to be approved by the health plan; (7) to require a health plan to provide a procedure under which providers and covered individuals may seek retroactive authorization for health care services that are medically necessary covered benefits; and (8) to prohibit a health plan from denying coverage for a health care service merely because prior authorization was not obtained for the health care service before it was provided to a covered individual if: (A) the health care service would have been a covered benefit if prior authorization had been obtained before the health care service was provided to the covered individual; (B) a determination of medical necessity can be made after the health care service is provided; and (C)

it is determined that the health care service was medically necessary. Defines “medically necessary” for use in these provisions.

SB 258

Prohibits a referring physician from receiving compensation or an incentive from a health care entity or another physician, who is in the same health care network as the referring physician, for referring a patient to the health care entity or other physician. Provides that the rules adopted by the department of insurance regarding the all payer claims data base must include a requirement that health payers report physician reimbursement rates for each contract and specify a process for health payers to report the physician reimbursement rates. Requires the all payer claims data base to publish the physician reimbursement rates as a separate line item for each contract instead of in the aggregate.

SB 3

Provides that a utilization review entity may only impose prior authorization requirements on less than 1% of any given specialty or health care service and 1% of health care providers overall in a calendar year. Prohibits a utilization review entity from requiring prior authorization for: (1) a health care service that is part of the usual and customary standard of care; (2) a prescription drug that is approved by the federal Food and Drug Administration; (3) medication for

opioid use disorder; (4) pre-hospital transportation; or (5) the provision of an emergency health care service. Sets forth requirements for a utilization review entity that requires prior authorization of a health care service. Provides that all adverse determinations and appeals must be reviewed by a physician who meets certain conditions. Requires a utilization review entity to provide an exemption from prior authorization requirements if in the most recent 12 month period the utilization review entity has approved or would have approved at least 80% of the prior authorization requests submitted by the health care provider for a particular health care service. Repeals superseded provisions regarding prior authorization. Makes corresponding changes.

SB 9

Requires health care entities to provide notice of certain mergers or acquisitions to specified members of the general assembly. Specifies notice requirements.

Summary of State Legislative Efforts Aimed at Health Care Transformation Reforms

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Employers using hospital price data to lower costs, push legislation

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Average annual healthcare cost in all 50 states

HB 1003

Health matters. Allows a credit against the state tax liability of an employer with fewer than 50 employees if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan and if the employer’s contribution toward the health reimbursement arrangement meets a certain standard. Requires employers that are allowed the credit to report certain information to the department of insurance. Provides that the total amount of credits granted to employers may not exceed $10,000,000 in a taxable year. Provides that the credit may be carried over for 10 years, but may not be carried back. Provides that a health care provider that enters into: (1) a value-based health care reimbursement agreement; and (2) an electronic medical record access agreement; with a health plan may qualify to participate in the health plan’s program to reduce or eliminate prior authorization requirements. Requires

a health plan that establishes a program to reduce or eliminate prior authorization requirements to provide certain information to health care providers concerning the program.

HB 1352

Telehealth services. Provides (beginning January 1, 2024) that the office of Medicaid policy and planning may not require: (1) a provider that is licensed, certified, registered, or authorized with the appropriate state agency or board and exclusively offers telehealth services to maintain a physical address or site in Indiana to be eligible for enrollment as a Medicaid provider; or (2) a telehealth provider group with providers that are licensed, certified, registered, or authorized with the appropriate state agency or board to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group.